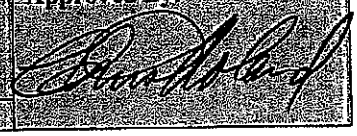
Effective Date: 9/96	Revised Date: 2/2007	Approved By: 
Location to be placed: Administrative Manual		

DEPARTMENT: **Housewide**

SUBJECT: **Charity Care**

I. Mission of the Hospital with Respect to Charity Care:

Tri-State Memorial Hospital recognizes a responsibility to the community to provide care to inpatients and outpatients, regardless of ability to pay, race, color, sex, religion, age, or national origin. Tri-State Memorial Hospital fulfills its legal responsibilities to provide these services without charge or at reduced charges as prescribed by WAC 261-14. In order to fulfill our commitment to provide charity care, the following criteria are required to assist hospital staff in making consistent, objective decisions regarding eligibility.

II. Description of Eligibility Criteria:

Charity care is generally secondary to all other financial resources available to the patient, including group or individual medical plans, worker's compensation, Medicare, Medicaid or medical assistance programs, other state, federal, or military programs, county aid, third party liability situations (e.g., auto accidents or personal injuries), or any other situation in which another person or entity may have a legal responsibility to pay for the costs of medical services.

In those situations where appropriate primary payment sources are not available, patients shall be considered for charity care under this hospital policy based on the following criteria as calculated for the 12 months prior to the date of request:

A The full amount of hospital charges will be determined to be charity care for any patient whose gross family income is at or below 100% of the current federal poverty guidelines (consistent with WAC 261-14-027).

For any patient whose gross family income is 101% to 200% of the current federal poverty guidelines. A discount of 75% will be applied to the patient account balance and will be determined as a charity care discount. The patient balance must be paid in accordance to the TSMH financial policy. At any time the patient balance is determined to be delinquent in accordance to the collection policy the discount of 75% will become null and void. At such time the patient will be responsible for the patient balance prior to the discount and any applicable finance charges.

For Washington residents whose gross family income is 201% to 300% of the current federal poverty guidelines. A discount of 35% will be applied to the patient responsibility. The patient balance must be paid in accordance to the TSMH financial policy. At any time the patient balance is determined to be delinquent in accordance to the collection policy the discount of 35% will become null and void. At such time the patient will be responsible for the patient balance prior to the discount and any applicable finance charges.

Dialysis patients receiving treatment at TSMH prior to the effective date of this policy will continue to be eligible for 100% charity assistance based on TSMH charity guidelines in place at the time treatment began. New Dialysis patients that do not have full coverage through Medicare, Medicaid or another payment source will be screened for eligibility. Their cost share will be determined on a case by case basis.

B. Prima Facie Write-offs: the hospital may choose to grant charity care based solely upon the initial determination. Any patient's who are on state assistance, are unemployed, disabled, transients or incompetent may be valid "prima-facie" candidates. In such cases, the hospital may not complete full verification or documentation of any request.

C. Catastrophic Charity Care: the hospital may apply a discount of 35% for Washington residents whose family income is in excess of 300% of the federal poverty guidelines. The patient must provide supporting financial documentation as proof of severe financial hardship or personal loss. The patient balance must be paid in accordance to the TSMH financial policy. At any time the patient balance is determined to be delinquent in accordance to the collection policy the discount of 35% will become null and void. At such time the patient will be responsible for the patient balance prior to the discount and any applicable finance charges.

III. Process for Eligibility Determination:

Initial Determination: The hospital will make an initial determination of eligibility based upon verbal or written application for charity care. Pending final eligibility determination, the hospital will not initiate collection efforts or requests for deposits, if the patient pays all or part of the hospital charges and subsequently is found to have met the charity care criteria at the time services were provided, the patient is entitled to a refund from the hospital within (30) days of approval of the charity care application. A determination will be made, provided that the responsible party is cooperative with the hospital's efforts to reach a determination, including return of applications and documentation within fourteen (14) days of receipt of a charity care application.

The hospital will exercise the following options:

A. The hospital shall use an application process for determining initial interest in and qualification for charity care.

B. Requests to provide charity care will be accepted from sources such as physicians, community or religious groups, social services, financial services personnel or the patient/family. If the hospital becomes aware of factors which might qualify the patient for charity care under this policy, it shall advise him or her of this potential and make an initial determination that such account is to be treated as charity care.

Final Determinations: The hospital will exercise the following options in making the final determination for charity care:

Option 1: Charity care may be granted based solely on the initial determination. In such cases, the hospital may not complete full verification or documentation of any request.

Option 2: Charity care forms, instructions and written applications shall be furnished to patients when charity care is requested, when need is indicated, or when financial screening indicates potential need. All applications, whether initiated by the patient or the hospital should be accompanied by documentation to verify income amounts indicated on the application form. The following documentation may be acceptable for purposes of verifying income; other may be requested:

- Pay stubs from all employment or
- A "W-2" withholding statement or
- Last year's income tax return or
- Letters approving or denying Medicaid, medical assistance, other benefits or
- Letters approving or denying unemployment compensation or
- Written statements from employers or welfare agents.

Option 3: Patients will be asked to provide verification of ineligibility for Medicaid or County Aid. During the initial request period, the hospital may pursue other sources of funding, including Medicaid.

Option 4: Income shall be based on a (12) month period starting from the date the application is received. Income will be calculated from the documentation provided by the patient or Medicaid. The process of calculation will be determined by the hospital and will take into consideration seasonal employment and temporary increases and/or decreases of income.

A. Time Frame for Final Determinations: The hospital shall provide final determination within (14) days of receipt of a complete application.

B. Denials/Appeals: Denials will be written and include instructions for appeal or reconsideration as follows: The patient/guarantor may appeal the determination of eligibility for charity care by providing additional verification of income or family size to the Patient Accounts Manager or designated representative. All appeals will be reviewed by the Chief Financial Officer. If this review affirms the previous denial of charity care, written notification will be sent to the patient/guarantor and the Department of Health, in accordance with state law. If the denial is reversed the patient shall immediately be declared an eligible candidate.

IV. Documentation and Records:

A. Confidentiality: All information relating to the application will be kept confidential. Complete copies of documents that support the application will be kept with the application form.

B. Documents pertaining to charity care shall be retained for four (4) years.

CHARITY CARE WORKSHEET

Date: _____ **Patient Financial Counselor:** _____

Patient: _____ **Guarantor:** _____

Account No(s): _____

☐ **Employed** ☐ **Unemployed** ☐ **Retired** **Insurance:** ☐ **No** ☐ **yes** _____

Service Dept(s): _____ Procedure: _____

Diagnosis: _____ Accident related: ☐ No ☐ Yes TPL: ☐ No ☐ Yes

Total Charges: $_____ **Requested Charity**

Adjustment

INS payments/adjustments: $_____ -

Finance Charge: $_____ +

Patient pymts to be refunded: $_____

Monthly Income: $_____ Yearly Income: $_____

Source of Income: _____ Source of verification: _____

Hospital Poverty Guideline for a family of _____ is $_____

Medicaid eligibility:

☐ Did not apply (worksheet attached)

☐ Not eligible on date of service Spend down ☐ No ☐ Yes - Spend down amount $_____

☐ Denied, reason for denial _____

Additional Comments: _____

Approval Signatures:

Business Office Supervisor (up to $500): _____

Chief Financial Officer ($500 to $2,500): _____

Chief Executive Officer ($2,500+): _____

Application denied: _____ Reason: _____

Application for Charity Care

Tri-State Memorial Hospital encourages you to apply for Charity Care if you are low income and need help paying hospital charges for inpatient or outpatient care. Charity Care may offer either free care or reduced-price care based on your eligibility and income. ***If you have questions or need help completing this application, please call*** *Patient Financial Counselor* ***at 509-758-4653.***

Please Print

Personal Information

Patient's Name: _____

If patient is a minor or a dependent, print name of parent or other responsible party:

_____Mailin

g Address:

_____

Telephone Number: Work ( ) _____ Home ( ) _____

Number of people in family (living in household): _____

Health Insurance information

Medical Insurance? Yes _____ No_____ If "yes," print name of insurance company:

_____

Policy Number: _____

Other Coverage? Yes ____ No ____ Please identify other coverage: _____

Medicare ___ Medicaid ___

Is the medical treatment because of a car accident or other third party injury?

Yes _____ No_____

Was the medical treatment because of an on-the-job injury or accident?

Yes _____ No _____

Income: Be sure to include with your application documents that give the income amounts you list below. For example:

- Pay stubs from all employment or
- A "W-2" withholding statement or
- Last year's income tax return or
- Letters approving or denying Medicaid, medical assistance, other benefits or
- Letters approving or denying unemployment compensation or
- Written statements from employers or welfare agents.

Current family monthly income (before taxes are taken out): $_____

Total family income for the past three months (before taxes):$_____

Has your family had any seasonal or temporary increases or decreases in income? Or, do you expect your income to change in the next three months?
Yes ____ No ____ If yes, please describe: _____

Have you recently suffered severe financial hardship or personal loss (for example, other medical expenses, death of a loved one, loss of job or wages, loss of home, auto, or other property)?
Yes ____ No _____ If yes, please explain: _____

Do the documents that you are including with this application show your current financial situation correctly?
Yes ____ No ____ If no, why not?_____

If you are asking for Charity Care for services already provided by Tri-State Memorial Hospital, please list dates of services and what services you received: _____

I understand that the information I am giving will be verified by Tri-State Memorial Hospital and reviewed by state and/or federal enforcement agencies and others as required. I certify that the above information is true and accurate to the best of my knowledge.

Applicant's Signature _____ Date _____

Mail this application with all documentation to:

Tri-State Memorial Hospital
1221 Highland Avenue
Clarkston, WA 99403

Tri-State Memorial Hospital provides hospital care to anyone, regardless of ability to pay.

Charity Care: Help for low income families with hospital expenses!

What is Charity Care? Charity Care is a way to help low income people and families pay for hospital medical services. Charity Care is either free care or reduced-price care, depending on your income.

Who is eligible for Charity Care? People and families with incomes within our income guidelines are eligible for Charity Care if they:

(1) do *not* have the financial resources to pay for care; and

(2) are *not* insured, that is covered by a group or individual medical plan, worker's compensation, Medicare, Medicaid, or any other state, federal, or military program; and

(3) are *not* involved in a situation where someone else has a legal responsibility to pay for the costs of medical services -- for example, an auto accident.

Important Note: *Tri-State Memorial Hospital does not discriminate based on age, race, color, national origin, religion, sex, handicap or disability.*

What does Charity Care cover? Charity Care applies to all appropriate hospital-based medical services. Hospitals are not required to provide charity care for non-hospital bases services and therefore hospitals are not required to cover physician services, long term care services, and transportation costs. Charity Care cannot be restricted to only patients who come to the hospital through the emergency department. Charity care applies to general inpatient and outpatient services provided in the hospital. Charity care does not need to be offered for cosmetic-type services or in limited other cases, such as other services that do not cure or prevent illness or infirmity.

How do I apply? To find out what is needed to prove you are eligible and what services will be covered, please contact: **Patient Financial Counselor Monday – Friday 8:00 a.m. to 5:00 p.m. at 509-758-4653 or in person at 1229 Highland Avenue.**

2007 TSMH POVERTY GUIDELINE

Size of Family	100% of poverty level 100% adjustment of charges 0% patient cost share	101% - 200% of poverty level 75% adjustment of charges 25% patient cost share	*201% - 300% of poverty level 35% adjustment of charges 65% patient cost share
1	$10,210	$20,420	$30,630
2	$13,690	$27,380	$41,070
3	$17,170	$34,340	$51,510
4	$20,650	$41,300	$61,950
5	$24,130	$48,260	$72,390
6	$27,610	$55,220	$82,830
7	$31,090	$62,180	$93,270
8	$34,570	$69,140	$103,710

*discount available for Washington state residents only.